

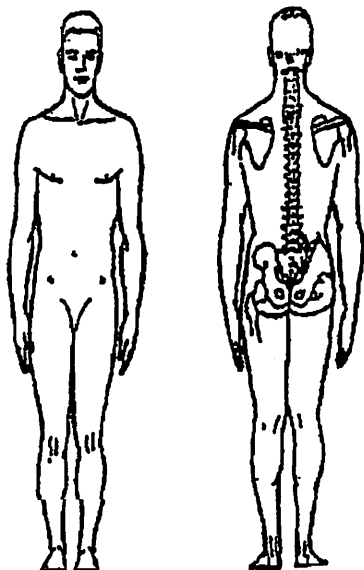
# INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist.

**PLEASE PRINT**

Today's Date \_\_\_\_\_  
 Name \_\_\_\_\_ Your SS# \_\_\_\_\_  
 Cell# \_\_\_\_\_ Phone Carrier: \_\_\_\_\_ Work# \_\_\_\_\_ EXT \_\_\_\_\_  
 Home # \_\_\_\_\_ Email: \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status: S M W D Number of Children \_\_\_\_\_

Please Circle payment type: CASH CHECK MASTER/VISA CARD  
 Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years on Job \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Do you have Medical Insurance? YES \_\_\_ NO \_\_\_ Insurance Company \_\_\_\_\_  
 Do you have Medicare? YES \_\_\_ NO \_\_\_ Do you have MEDICAID? YES \_\_\_ NO \_\_\_  
 Name of Spouse or Parent \_\_\_\_\_ Their Birthday \_\_\_\_\_  
 Spouse Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Years on Job \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone# \_\_\_\_\_ Does your spouse have Health Insurance at work? Y \_\_\_ N \_\_\_



### COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.

### MAJOR COMPLAINTS

(Please list any conditions you are being treated for or experiencing)

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Referred to our office by: \_\_\_\_\_  
 Is this condition due to an accident? Y \_\_\_ N \_\_\_ Date of accident: \_\_\_\_\_  
 Type of accident: Auto \_\_\_ Work/on the job \_\_\_ At Home \_\_\_ Other \_\_\_\_\_  
 Have you ever been in an auto accident? Y \_\_\_ N \_\_\_ Past Year \_\_\_ Past 5 Years \_\_\_ over 5 Years \_\_\_  
 How payments will be made:  
 CASH \_\_\_ CHECK \_\_\_ CREDIT CARD \_\_\_ WORKER'S COMP \_\_\_ INSURANCE \_\_\_  
 Type of Insurance: MEDICAL INSURANCE \_\_\_ AUTOMOBILE INSURANCE POLICY \_\_\_

# Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name \_\_\_\_\_ Date \_\_\_\_\_

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

**O – OCCASIONAL F – FREQUENT  
C – CONSTANT**

**O F C**

**GENERAL**

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

**MUSCLE & JOINT**

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders

**PAIN OR NUMBNESS IN:**

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful tail bone
- Poor posture
- Sciatica
- Spinal Curvature
- Swollen joints

**O F C**

**GASTRO-INTESTINAL**

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

**EYES, EARS, NOSE  
& THROAT**

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

**O F C**

**CARDIO-VASCULAR**

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

**RESPIRATORY**

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

**SKIN**

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

**GENITO-URINARY**

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

**FOR WOMEN ONLY**

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge

Yes  No Are you pregnant?

**CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cold sores     | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Scarlet fever    |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Gout          | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Typhoid fever    |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Lumbago       | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Malaria       | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea           | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles       | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Whooping cough   |

List surgical operation and years: \_\_\_\_\_

Drugs you now take:  Nerve pills  Pain killers  Muscle relaxers  
 "Pep" pills  Tranquilizers  Birth control pills

Others: \_\_\_\_\_

Age of mattress: \_\_\_\_\_  Comfortable  Uncomfortable  Do you use a bed board? \_\_\_\_\_

Are you wearing:  Heel lifts  Sole lifts  Inner soles  Arch supports

Have you been in an auto accident:  Past year  Past five years  Over five years  Never

Describe: \_\_\_\_\_

Have you ever had any mental or emotional disorders?  Yes  No When? \_\_\_\_\_

Have others in your family had such disorders?  Yes  No When? \_\_\_\_\_

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized for anything other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DO YOU:	Yes	No	DESCRIBE BRIEFLY
Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Think you may need vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IN CASE OF EMERGENCY (Name of relative or close friend not living in your home): NAME \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

# DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC INFORMED CONSENT

## CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying cause, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

## ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premises that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

## DIAGNOSIS

Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other options if he/she has any concerns as the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

## INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic test, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom causes any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnosis and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

## RESULTS

The purpose of Chiropractic service is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule of efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite to all problems. Both have great strides in alleviating pain and controlling disease.

## TO THE PATIENT

Please discuss any questions or problems with the Doctor **before** signing this statement of policy.

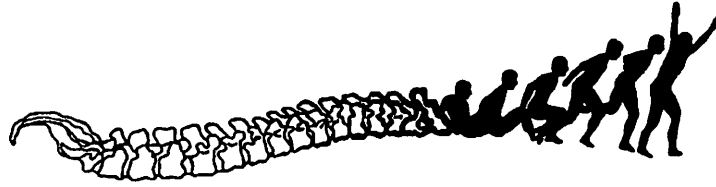
I have read and understand the forgoing.

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SIGNATURE

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DATE



## Lakeview Center Chiropractic Acupuncture & Massage Office Policy

The following is an explanation of our clinic policies. We believe that clear definition will allow us both to concentrate on the most important issue: regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account or insurance coverage.

### **No Charge Consultation for Chiropractic**

Lakeview Center Chiropractic will do a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problem. There is no charge or obligation in connection with this appointment.

### **Patient Payment Policy**

We feel the patient's health needs are paramount; therefore our payment policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

### **New Patient Care Services**

We require payment of the first visit charges on the same day of service. If we are billing your insurance then payment of your deductible and any applicable co-pay is expected on the first day of service. Properly documented worker's compensation and accident claims are not required to pay at this time if appropriate forms and leins are signed. However, if at any time your auto insurance denies payment - you are responsible for paying that amount. Payment will be expected within 30 days.

### **Established Patient Care Services**

Patients under care are required to make regular payments, at the time of visit, or in advance, on all unpaid balances, except for properly documented worker's compensation or auto injury claims. However, if at any time your auto insurance denies payment - you are responsible paying that amount. Payment will be expected within 30 days. We may at our option charge on percent interest on all account balances over 30 days.

You will receive a monthly statement with all of your charges itemized. Please review these and retain for your records (taxes, etc.)

## **Our Policy on Health Insurance**

Today most insurance policies do cover chiropractic/massage/acupuncture care. We will be happy to file your primary insurance claim for you and do anything we can to assure you receive proper reimbursement; however, we cannot take responsibility for what your health insurance will or will not cover.

Most insurance policies do cover chiropractic/massage/acupuncture care. However, if yours does not, we encourage you to urge your employer or health insurance broker to change your policy to one that does. Your freedom to choose your own health care provider is a fundamental right. If we can help in any way please let us know. Lakeview Center Chiropractic Acupuncture and Massage has patient payment options for those without health insurance.

It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, their insured. Of course, Lakeview Center Chiropractic Acupuncture and Massage will prepare any necessary reports and forms to assist you in making collection from your insurance company. Furthermore, any amount authorized to be paid directly to Lakeview Center Chiropractic Acupuncture and Massage will be credited to your account on receipt.

However, you must clearly understand and agree that all services rendered to you are charged directly to you and that you are personally responsible for payment.

## **Appointments**

It is important that you keep all of your agreed to and scheduled appointments. We ask that you call if you are unable to make your appointment or if you will be late. We have a 24 hour cancelation policy. We charge \$50 for late cancelations, this is a direct fee to the patient. All missed appointments need to be made up as soon as possible in order to achieve positive response to care. Please help us to help others.

## **Emergency or After Hour Calls**

In case of an emergency you may contact the office for a special appointment any time during regular office hours. If you, a friend or family member require after hours or weekend assistance, you may call the clinic for special assistance.

## **Questions And Answers**

Your questions about any aspect of your care or account are invited. Please feel free to ask your doctor or any available staff member. We will make every effort to answer your inquiries.

I have read the Lakeview Center Chiropractic Acupuncture and Massage Policies and will honor them:

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Patient's Signature

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Date

Disclaimer:

This document and the information in it does not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPPA regulations.

**NOTICE: PATIENT PRIVACY**

**Date: APRIL 1, 2003**

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

**HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.**

We are required by law to have your written consent before we use or disclose to others your medical information for purpose of providing or arranging for your healthcare, the payment for or reimbursement of the care that we provided to you, and related administrative activities supporting your treatment.

We may be required or permitted by certain law to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have the available a detailed Notice of Privacy Practices which fully explains your rights and our obligation under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

If you have any questions, concerns or complaints about the Notice or your medical information please contact Dr. Daren J Penry at Lakeview Center Chiropractic.

\_\_\_\_\_  
NAME

\_\_\_\_\_  
DATE